AUTHORIZATION FOR RELEASE OF MEDICAL AND PSYCHIATRIC PATIENT RECORDS AND INFORMATION

CITY OF SANTA BARBARA Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

PARTICIPANT (PATIENT) NAME _____ Date of Birth _____

Social Security Number (optional) _____

I, the undersigned, hereby authorize:

Physician or medical facility name _____

Name of participant's school district if participant is a minor _____

to release records and information developed in the course of the diagnosis and treatment of the patient listed above, including medical and psychiatric records, to the City of Santa Barbara Parks and Recreation Department.

This disclosure of medical records and/or information is for the purpose of evaluating the patient's participation in recreation programing offered by the City of Santa Barbara Parks and Recreation Department and to determine what conditions, restrictions or accommodations, if any, are warranted for the patient's participation.

This release shall become valid immediately and shall remain in effect for the length of the patient's participation in the recreation program.

A copy of this authorization shall be as valid as the original. The undersigned has a right to receive a copy of this authorization if a copy is requested.

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____